# SCOPE OF SERVICES

*Neurology*

| Last Name | First Name | Middle Name |
|---|---|---|
| | | |

Check appropriate box indicating which clinical capabilities you are willing and able to perform

**Please list any limitations on a separate sheet**

| Neurology | | | |
|---|---|---|---|
| | Admission, evaluation, consultation and treatment of non-surgical therapy to patients presenting with Parkinsonism, seizure disorders, meningitis/encephalitis acute strokes, rehabilitative strokes, status epilepticus and other neurological disorders or injuries | | ADULTS<br>PEDS |
| | | | |
| | Consultation, evaluation, and provision of non-surgical therapy to patients presenting with Parkinsonism, seizure disorders, meningitis/encephalitis, acute strokes, rehabilitative strokes, status epilepticus and other neurological disorders or injuries | | ADULTS<br>PEDS |
| | | | |
| | Lumbar punctures, CPR, Interpretation of Electroencephalograms, EMG, Nerve Conduction Studies<br><br>***Pediatrics (birth to 18 years)** | | ADULTS<br>PEDS |

**Signing below indicates that I am qualified to perform the services chosen on the checklist**

| Signature | Date |
|---|---|
| | |